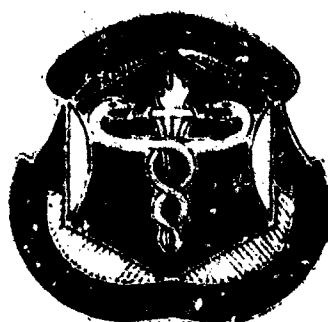


ILLNESS BEHAVIOR AND TRANSITIONAL <sup>①</sup>  
STATES: A STUDY OF OUTPATIENT  
RATES AND SYMPTOM PRESENTATION  
IN RELATION TO TROOP DEPLOYMENT  
DURING PEACETIME

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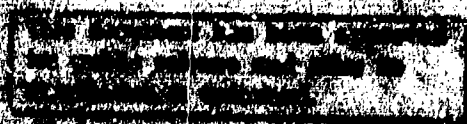
TECHNICAL REPORT 3

TYPES AND RATES OF OUTPATIENT  
SICKCALL VISITS

JUNE 1980 - MAY 1981

COMBAT ARMS AND SUPPORT TROOPS

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20. ABSTRACT (Continue on reverse side if necessary and identify by block number) The outpatient sickcall visits during June 1980-May 1981 for soldiers and their family members in 17 highly stressed combat arms (airborne) and 5 less stressed support companies were collected and linked to the sponsor's personnel data as part of the "Health Consequences of Deployment" study. The findings describe the demographic characteristics and attributes of the soldiers-at-risk, ratio as a function of stress for the principal reason for visit categories, the most common presenting problems and the presenting problem rate ratios. Appendices specify the codes included in the major categories.		

**The Health Consequences of Deployment,  
Technical Report 3:  
Types and Rates of Outpatient Sickcall Visits  
June 1980 - May 1981  
Combat Arms Troops and Support Troops**

CPT Linda K. Jellen, MSW  
Joseph M. Rothberg, Ph.D.

6 December 1982



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## INTRODUCTION

The findings in this report describe the June 1980 through May 1981 outpatient sickcall visits gathered for the active duty sample in the "Health Consequences of Deployment Study" (1) in terms of differences between the combat arms soldiers and support soldiers. Other technical reports based on this study are listed in Appendix A.

The combat and support groups are different in several ways. They were picked for the vast differences in their military duties. The combat soldiers spent much more time in rigorous physical training such as field exercises and road marches. They are all paratroopers who must jump at least once every 90 days and frequently do so much more often. They are periodically on alert to be able to deploy within 48 hours. The support soldiers have essentially sedentary jobs. Their morning physical training (PT) is generally warm-up exercises and a run three times a week. These differences allow us to highlight the medical problems related to highly stressed soldiers.

The clinics providing first line care to these two groups were also different. The combat arms unit had Battalion Aid Stations (BAS) to provide medical care to each battalion (approximately 660 soldiers each) and a Troop medical Clinic (TMC) which provided care to the two headquarters units (as well as other non sample units). The support units received their medical care at two TMC's which served approximately 2100

soldiers, only a fraction of whom were in the sample population. The completeness and availability of sick call sign-in logs and medical records was better at the combat soldiers' BAS than the support soldiers TMC.

There are seventeen combat arms units which make up one brigade in our sample; this includes three battalions of five companies each plus a brigade headquarters and an anti-tank company. The five support companies are from a different, and higher level, support command and include finance, data processing, personnel, administration, and parachute rigging companies.

The average strength for the year was 2,195 for the combat units and 743 for the support units. There were some relative demographic differences between these two groups. Table 1, based on a midyear (November 1980) personnel tape, shows that there were more E1 thru E4's in the combat arms units than the support units. The combat arms units had no females while the support units were about one sixth female. There were more caucasians in the combat arms units and more of the combat soldiers were single. More combat soldiers had no PULHES profiles (medical limitations on military assignments) compared to support soldiers. The mean age is younger for combat soldiers than for support soldiers. The combat soldiers' mean number of months on post is also greater. In summary the combat soldiers were primarily younger, had less rank, fewer were

married, all were male, more were caucasian, more had no permanent profiles and more had been stationed at the post longer.

The data in this report will be discussed in terms of the total number of outpatient sickcall visits and the annual rates of visits (per 100 strength). The findings will be displayed at several different levels of aggregation. The Category of Visits is a classification of the presenting problem into different modules as set forth in the Public Health Service's "A Reason for Visit Classification for Ambulatory Care" (2) which was used to code the visits in this study. Several of these modules represent visits for symptoms or diseases of the various body systems such as the respiratory or digestive system. Other modules represent specific types of visits regardless of body systems. For example, this classification places visits for family planning, PAP smears or pregnancy tests in the Diagnostic/Screening/Prevention Module rather than the Genito-Urinary Module. Some of the other modules (and non-inclusive examples of the types of visits they represent) are as follows: The Injury module represents injuries of all types (cuts, burns, etc.) to all parts of the body. The Diagnostic/Screening/Prevention module includes visits for a general medical check-up, various blood tests, blood pressure checks, hearing tests, pregnancy tests, PAP smears and family planning. The Treatment module includes visits for cast and

suture care and bandage changes. The Administrative module includes visits made at the request of a third party, such as command psychiatric exams or annual physical exams.

In order to be sure the most frequent individual reasons for visits are not overlooked in the various modules, individual presenting problems will also be arrayed according to the frequency of their occurrence. The specific presenting problem represents the reason for the visit provided by the patient as indicated in various clinics' sign-in log. "Complaint Not Given" was used when the reason for the visit was not indicated in the sign-in log.

Injuries and the resulting visits represent a very large fraction of the health care delivered to this population. Based on this, we created a classification to summarize the visits into three major groups: Muscular/Skeletal Complaints and Injuries (M/S & I), Other Disease and Symptoms (O D/S), and Other visits (O). The O D/S Category represents (non-injury) Illness, Visits and the O Category is a catch-all for other visits, such as Diagnostic/Screening/Prevention, Administrative, or Uncodable. Appendix B lists the specific categories included in each of these major groups. The background and general methodology for this report is found in Technical Report 1, "The Health Consequences of Deployment: The Data Gathering System"(3).

The relative risk ratio used to compare categories of visits was computed as the combat soldiers annual rate of visits

per 100 strength divided by the support soldiers rate of visits per 100 strength. Significance was tested at the .05 level with the Z-score derived from the standard error of the mean.

#### Findings and Discussion

The combat soldiers had an annual sickcall rate that was almost half again higher than the support soldiers (483/100 versus 329/100). This ratio was somewhat reduced (from 1.47 to 1.34) when the rates for combat and support soldiers were calculated only for those dates when the combat soldiers were on the most comparable (i.e., support) phase of their readiness cycle (see Technical Report 5 for an extended discussion of the relation of the activity of combat soldiers and their outpatient sickcall rates). There were also differences of the rates in most of the categories of visits modules as shown in Table 2. The only modules that were not different were General Symptoms, Nervous System, Ear and Eye, Genito-Urinary and Test Results. As indicated by the relative risk column the combat soldiers are almost three times as likely to have Skin, Hair and Nail problems, more than twice as likely to have Injury visits, and almost twice as likely to have Mental Health visits, Diagnostic/Screening/Prevention visits, and Treatment visits. In the following paragraphs, we will consider these five modules in turn.

In the Skin, Hair and Nail module, the annual rate was



58.2/100 strength for the combat soldiers and 21.3/100 for the support soldiers. The specific skin, hair and nail presenting problems shown in Table 3, differed between combat and support soldiers with the exception of ingrown nails and other nail problems and symptoms. The most notable differences were for blisters, skin infections, rashes and poison ivy or oak. These differences are consistent with the amount of time that the combat soldiers spend marching, running and in field training exercises (FTX) (See Technical Report 3: "Impact of Activity and Transitional states on Combat Arms Soldiers Outpatient Sickcall Rates").

In the Injury module, the annual sickcall visit rate was 81.6/100 strength for the combat soldiers and 33.0/100 strength for the support soldiers. A one week sample of injury visits for the combat soldiers at the BAS's indicated that the majority of injuries occurred in three situations: field exercises, parachute jumps, or athletic physical training (See Technical Report 4: "Additional Survey of Injury of Combat Soldiers").

The support soldiers have lower exposure to situations with high risks of injury. They have virtually no field duty, the majority are not in airborne units (only the parachute rigging company is airborne), and generally do not have football games for their organized PT. Table 4 shows the specific presenting problems for injury visits. All of these categories were different with the exception of Unspecified and Multiple

Injuries. The combat soldiers had more than five times the risk for insect bites, which most likely reflects the large amount of time they spent in the field. They were at twice the risk for injury to all body parts (extremities, trunk, etc.) as well as in the Accidents and Injuries category. This category includes auto accidents, fights, falling down stairs, overdoses, etc.

In the Mental Health module, the annual rate was 5.6/100 strength for combat soldiers and 2.8/100 for support soldiers, as seen in Table 2. As mentioned in the methodology section, this included only visits that received a mental health code and does not include all visits made to the mental health clinics. Table 5 shows the rates for mental health problems for visits that received mental health codes as well as all other visits to the mental health clinic. When we counted all visits to the Mental Health Clinic (including those that the RVC code book did not designate as a mental health problem), the number of visits for soldiers increased from 122 to 234, and for support troops it increased from 21 to 59. The three types of visits to the mental health clinics that were not coded as mental health presenting problems are shown as the last three categories in Table 5. Command ordered psychiatric evaluation for schools such as sniper school (the majority of such evaluations) or drill sergeant school or for a discharge increased the combat soldiers visits by 61 and the support visits by seven. The "Other" Mental Health clinic visits category included visits for

headaches and high blood pressure, for example, which evidently had been referred from other medical clinics. This type of visit increased the combat visits by 32 and the support soldiers visits by 19. The use of "no complaint given" indicated that a visit to a mental health clinic was made but a presenting problem was not recorded and we were unable to ascertain the reason for the visit. There were 19 such visits for combat soldiers and 12 for support. This increased the annual rates to 10.7/100 for combat soldiers and 7.9/100 for support soldiers. These were still significantly different at the .05 level. The relative risk ratio was lowered to 1.35 from 1.97.

The relative risk ratio for marital or family problems was only slightly less than one. This may be accounted for by the fact that more of the support soldiers were married and more had one or more dependents.

There were very few visits for anxiety, depression, identity or behavior problems or other personality disorders for the support soldiers (2 visits) and quite a number for the combat soldiers (51 visits). There are several possible variables that may influence these differences in mental health problems. First, the combat units have more younger, first term soldiers who could still be experiencing some situational adjustment stress. Second, being a paratrooper in an elite combat arms unit that works hard, plays hard, has frequent deployments and has some inherent dangers in its mission may

cause increased stress among its' soldiers which results in increased mental health problems. Third, these two groups received most of their mental health care at different clinics; perhaps there are differences in the use of various presenting problems in the records at these clinics.

Because of the importance of mental health to the evaluation of health and stress, a separate technical report (Technical Report 9, "Characterization of Active Duty and Family Members Who Make Mental Health Visits") will explore this area in depth. That report will include a registry of individuals and families with mental health visits which will examine the demographics and the relationship between mental health visits and other health visits.

The annual rates for Diagnostic/Screening/Prevention module visits was 41.4/100 strength for combat troops and 21.3/100 strength for support troops. The greatest difference in specific presenting problem between these two groups of soldiers was for eye exams, general medical exams and x-ray. The rates for Treatment module visits were 19.9/100 strength and 10.1/100 respectively. The differences in visits were primarily in the categories of sutures, cast and bandages as well as dental visits. Some of these differences in visits of both these modules may represent differences in the health care management system, i.e., better recordkeeping in BAS than the TMC. Others are inter-related, such as large numbers of injuries and large

numbers of treatment visits for casts and large numbers of diagnostic visits for x-rays, etc. Some, such as eye exams and dental visits, may indicate more command emphasis on prevention in the combat units.

The six most frequent specific present specifying problems which account for about 25% of the visits for combat soldiers are knee symptoms, head cold, skin rash, foot symptoms, throat symptoms, and ankle symptoms. For the support soldiers, the four most frequent presenting problem entries which account for about 25% of the visits are no complaint given, throat symptom, foot symptom and back symptom.

A rank ordered listing of the top 20 presenting problems for combat and support soldiers may be found in Table 6 and Table 7. By inspection of these tables, it appears that combat and support soldiers have different presenting problems. To quantify these differences, the ratio of the outpatient sickcall rates (combat rate divided by support rate) was computed for all presenting problems which had 5 or more visits by support soldiers. The 10 largest and 10 smallest values of this ratio are seen as table 8. The effects of combat training appear as the high ratio problems and the effects of having females in the support units show up as the low ratio problems. Diarrhea is the only high ratio individual presenting problem which did not come from one of the high risk modules discussed above.

Table 9 shows the demographic description of the sickcall

visitors for combat and support soldiers. This Table describes the attributes and characteristics as of the last visit per soldier and does not include multiple visits by a single individual. The comparison of the soldiers who had sick call visits with the estimated population at-risk was done for each of the characteristics and attributes. The values of the observed distributions from Table 9 were compared to the expected distributions derived from Table 1 using chi-square or z-score statistical tests and none of the characteristics or attributes were distributed differently in the sick call visitors compared to the population at-risk. Factors which are not currently different may become statistically significant when computed with the larger numbers from two years of data or when the exact population at-risk is used. Technical Report 7, "Demography, Unit Personnel Turnover and Outpatient Visits explores in depth the impact of various demographics on rates and types of visit.

#### FOOTNOTES

1. "Illness Behavior and Transitional States: A Study of Outpatient Rates and Symptom Presentation in Relation to Troop Deployment During Peacetime," Linda K. Jellen, and Joseph M. Rothberg, WRAIR, Washington DC.

2. A Reason for Visit Classification for Ambulatory Care, D. Schneider, DHHS-PHS 79-1352, Washington DC, 1979.

3. The Health Consequences of Deployment. PART I: Data Gathering. J.M. Rothberg and L.K. Jellen, Technical Report 82-1, Dept Mil Psychiatry, WRAIR, Washington DC, 1982.

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**TABLE 1: DEMOGRAPHIC CHARACTERISTICS AND ATTRIBUTES OF COMBAT AND SUPPORT SOLDIERS PRESENT IN 22 UNITS DURING NOVEMBER 1980.**

GRADE	COMBAT		SUPPORT	
	n	(%)	n	(%)
OFFICERS	103	(5%)	21	(3%)
E1-E4	1446	(68%)	431	(56%)
E5-E6	474	(22%)	267	(35%)
E7-E9	106	(5%)	50	(7%)
SEX				
FEMALE	0	0	151	(20%)
MALE	2129	(100%)	618	(80%)
RACE				
CAUCASIAN	1499	(70%)	355	(46%)
NEGRO	468	(22%)	364	(47%)
OTHER	162	(8%)	50	(7%)
MARITAL STATUS				
SINGLE	1259	(59%)	340	(44%)
MARRIED	807	(38%)	326	(42%)
OTHER	63	(3%)	103	(13%)
EDUCATION				
NOT HIGH SCHOOL GRADUATE	291	(14%)	100	(13%)
HIGH SCHOOL GRADUATE	1608	(76%)	559	(73%)
BEYOND HIGH SCHOOL	230	(11%)	110	(14%)
PULHES				
111111	1645	(75%)	474	(62%)
NOT 111111	484	(23%)	295	(38%)
DEPENDENTS				
NONE	1285	(60%)	376	(49%)
ONE	310	(15%)	143	(19%)
TWO OR MORE	534	(25%)	250	(33%)
MEAN GT SCORE	106.8		106.4	
(Standard Deviation)	(14.9)		(13.1)	
MEAN AGE, YEAR	23.5		25.2	
(Standard Deviation)	(4.9)		(5.7)	
MEAN TIME AT POST, MONTHS	22.1		19.1	
(Standard Deviation)	(19.1)		(17.3)	



TABLE 2: NUMBER AND ANNUAL RATE PER 100 OF OUTPATIENT SICKCALL VISITS JUNE 1980 - MAY 1981.

PRINCIPAL REASON FOR VISIT*	COMBAT UNITS		RATIO **	SUPPORT UNITS	
	n	RATE/100		n	RATE/100
ALL VISITS	10597	482.8	1.47	2444	328.9
INJURY	1792	81.6	2.48	245	33.0
BODY SYSTEMS					
MUSCULAR/SKELETAL	2507	144.2	1.55	549	73.9
GENERAL SYMPTOMS	393	17.9	.89	150	20.2
MENTAL HEALTH	122	5.6	1.97	21	2.8
NERVOUS SYSTEM	180	8.2	1.13	54	7.3
EYE & EAR	342	15.6	1.22	95	12.8
HEART & BLOOD	71	3.2	1.85	13	1.7
RESPIRATORY	1265	57.6	1.27	336	45.2
DIGESTIVE	555	25.3	1.38	136	18.3
GENITO-UNINARY	179	8.2	.87	70	9.4
SKIN HAIR & NAILS	1277	58.2	2.72	159	21.4
TEST RESULTS	22	1.0	.93	8	1.1
TREATMENT	909	41.4	1.95	158	21.3
DIAGNOSTIC/SCREENING /PREVENTION	434	19.8	1.96	75	10.1
ADMINISTRATIVE	87	.3	.24	10	1.3
UNCODABLE & OTHER	462	21.0	.43	365	49.1

\* See Appendix B for RVC codes in each category.

\*\* Relative risk ratio of rate in combat units divided by rate in support units.

**TABLE 3: NUMBER AND ANNUAL RATE PER 100 FOR SKIN, HAIR AND NAIL VISITS, JUNE 1980 - MAY 1981.**

TYPE OF VISIT*	COMBAT UNITS		RATIO **	SUPPORT UNITS	
	n	RATE/100		n	RATE/100
BLISTERS & OTHER LESIONS	131	6.0	8.57	5	.7
SKIN INFECTIONS (ACNE, BOILS ETC)	119	5.4	4.90	8	1.1
CALLUS & OTHER GROWTHS	182	8.3	2.59	24	3.2
POISON IVY, RASHES & OTHER SKIN IRRITATIONS	619	28.2	2.25	93	12.5
INGROWN NAILS & OTHER NAIL PROBLEMS	46	2.1	1.75	9	1.2
OTHER SYMPTOMS & DISEASES S,H, & N	80	3.6	1.33	20	2.7
MOLES & WARTS	100	4.6	***	0	0
<b>TOTAL</b>	<b>1277</b>	<b>58.2</b>	<b>2.72</b>	<b>159</b>	<b>21.4</b>

\* See Appendix C for RVC codes in each category.

\*\* Relative risk ratio of rate in combat units divided by rate in support units.

\*\*\* Denominator has less than 5 visits; relative risk not computed.

**TABLE 4: NUMBER AND ANNUAL SICKCALL RATE PER 100 FOR INJURY VISITS, JUNE 1980 - MAY 1981.**

TYPE OF INJURY*	COMBAT UNITS		RATIO SUPPORT UNITS	
	n	RATE/100	**	n RATE/100
INSECT BITES	108	4.9	5.44	7 .9
LOWER EXTREMITIES	622	28.3	2.57	82 11.0
TRUNK	109	<del>5.0</del>	<del>2.50</del>	<del>15</del> 2.0
HEAD,FACE,NECK	230	10.5	<del>2.28</del>	<del>34</del> 4.6
OTHER ACCIDENTS & INJURIES	195	<del>8.9</del>	2.23	30 4.0
UPPER EXTREMITIES	336	15.3	2.10	54 7.3
UNSPECIFIED OR MULTIPLE INJURIES	107	4.9	1.75	21 2.8
SPECIFIED JUMP INJURIES	85	3.9	***	2 .3
<b>TOTAL</b>	<b>1795</b>	<b>81.6</b>	<b>2.48</b>	<b>245 33.0</b>

\* See Appendix D for RVC codes included in each category.

\*\* Relative risk ratio of rate in combat units divided by rate in support units.

\*\*\* Denominator has less than 5 visits; relative risk not Computed.

**TABLE 5: NUMBER AND ANNUAL OUTPATIENT RATES PER 100 OF ALL MENTAL HEALTH VISITS AND VISITS TO MENTAL HEALTH CLINICS JUNE 1980 - MAY 1981.**

TYPE OF VISIT*	COMBAT UNITS		RATIO **	SUPPORT UNITS	
	n	RATE/100		n	RATE/100
MARITAL/FAMILY	42	1.9	.95	15	2.0
OCCUPATIONAL, SOCIAL ECONOMIC OR EDUCATION	22	1.0	***	3	.4
ANXIETY, DEPRESSION, AND SLEEP DISORDERS	20	0.9	***	2	0.3
ANGER, INDENTITY, OR BEHAVIORAL PROBLEM	17	0.8	***	0	0
PERSONALITY DISORDERS AND OTHER PSYCHIATRIC SYMPTOMS	14	0.6	***	0	0
DRUG, ALCOHOL	7	0.3	***	1	0.1
ADMINISTRATIVE PSYCHIATRIC EXAM	61	2.8	3.11	7	0.9
OTHER REASONS	32	1.5	.58	19	2.6
NO COMPLAINT GIVEN	19	0.9	.56	12	1.6
<b>TOTAL</b>	<b>324</b>	<b>10.7</b>	<b>1.35</b>	<b>59</b>	<b>7.9</b>

\* See Appendix E for RVC codes in each category.

\*\* Relative risk ratio of rate in combat units divided by rate in support units.

\*\*\* Denominator has less than 5 visits; relative risk not computed.

TABLE 6: NUMBER AND ANNUAL SICKCALL VISIT RATE PER 100 OF THE  
MOST COMMON PRESENTING PROBLEMS: COMBAT SOLDIERS, JUNE 1980 - MAY 1981.

	<u>n</u>	<u>RATE/100</u>
1. KNEE SYMPTOMS	566	25.8
2. HEAD COLD	533	24.3
3. SKIN RASH	486	22.1
4. FOOT SYMPTOMS	449	20.5
5. THROAT SYMPTOMS	335	15.3
6. ANKLE SYMPTOMS	288	13.1
7. BACK SYMPTOMS	278	12.7
8. NO COMPLAINT GIVEN	249	11.3
9. EYE EXAMINATION	235	10.7
10. FLU	192	8.7
11. CONSULT TO DENTAL CLINIC	187	8.5
12. LEG SYMPTOMS	182	8.3
13. OTHER GROWTHS SKIN	182	8.3
14. PROGRESS VISIT, NOS	170	7.7
15. STOMACH PROBLEM	169	7.7
16. LOW BACK SYMPTOM	156	7.1
17. HEADACHE	150	6.8
18. CONSULT UNSPECIFIED CLINIC	141	6.4
19. SHOULDER SYMPTOM	135	6.2
20. FOOT INJURY	134	6.1

TABLE 7: NUMBER AND ANNUAL SICKCALL VISIT RATE PER 100 OF THE  
20 MOST COMMON PRESENTING PROBLEMS: SUPPORT SOLDIERS, JUNE  
1980 - MAY 1981.

<u>RANK PRESENTING PROBLEM</u>	<u>n</u>	<u>RATE/100</u>
1. NO COMPLAINT GIVEN	289	38.9
2. THROAT SYMPTOM	147	19.8
3. FOOT SYMPTOM	134	18.0
4. BACK SYMPTOM	99	13.3
5. HEAD COLD	90	12.1
6. SKIN RASHES	80	10.8
7. KNIFE SYMPTOMS	66	8.9
8. STOMACH PROBLEMS	66	8.9
9. FLU	63	8.5
10. LEG SYMPTOMS	58	7.8
11. ANKLE SYMPTOMS	52	7.0
12. CHEST PAIN	48	6.5
13. HAND SYMPTOMS	40	5.4
14. PAIN, NO SPECIFIC SOURCE	37	5.0
15. HEADACHE	35	4.7
16. INADEQUATE INFORMATION	32	4.3
17. PROGRESS VISIT	32	4.3
18. TO SEE DOCTOR	32	4.3
19. FOOT INJURY	30	4.0
20. MEDICATION	29	3.9

**TABLE 8: HIGHEST ANNUAL SICKCALL AND LOWEST ANNUAL SICKCALL  
PRESENTING PROBLEM RATE RATION JUNE 1980 - MAY 1981.**

PRESENTING PROBLEM	COMBAT	SUPPORT	RATE RATIO
	VISITS n	VISITS n	
UNCONFIRMED PREG	0	14	0
FAMILY PLANNING	0	5	0
CONSULT OB/GYN	0	13	0
VAGINAL BLEEDING	0	6	0
FEM REPRO SYSTEM PROB	0	11	0
COUNSELLING, NOS	16	32	0.17
TEST RESULTS, NOS	3	5	0.24
SYMP SKIN	5	7	0.24
GEN PSYCH EXAM	5	6	0.28
GEN FEELING ILL	11	13	0.29
CUTS U EXTREM	102	7	2.9
KNEE SYMP	566	66	2.9
KNEE INJ NOS	124	14	2.3
SHOULDER INJ NOS	46	5	3.1
SHOULDER SYM	235	14	3.3
FUNGUS INF	49	5	3.3
ANKLE INJ NOS	94	9	3.5
DIARRHEA	89	7	4.3
INSECT BITE	108	7	5.2
SKIN LESION	131	5	8.9

\* Rate Ratio: Combat by support, not done for support under 5.

**TABLE 9: DEMOGRAPHIC CHARACTERISTICS OF OUTPATIENT SICK CALL VISITORS FROM COMBAT AND SUPPORT UNITS, JUNE 1980 - MAY 1981, AS OF LAST VISIT PER SOLDIER.**

	<u>COMBAT</u>		<u>SUPPORT</u>	
<b>GRADE</b>				
OFFICERS	83	(4%)	29	(5%)
E1-E4	1640	(69%)	390	(54%)
E5-E6	542	(23%)	237	(36%)
E7-E9	100	(4%)	37	(4%)
<b>SEX</b>				
FEMALE	0		149	(22%)
MALE	2365	(100%)	544	(78%)
<b>RACE</b>				
CAUC	1676	(71%)	329	(47%)
NEGRO	520	(22%)	328	(47%)
OTHER	169	(7%)	36	(5%)
<b>MARITAL STATUS</b>				
SINGLE	1424	(60%)	306	(44%)
MARRIED	878	(37%)	294	(42%)
OTHER	63	(3%)	93	(13%)
<b>EDUCATION</b>				
NOT HIGH SCHOOL GRADUATE	319	(13%)	87	(13%)
HIGH SCHOOL GRAUATE	1830	(77%)	503	(73%)
BEYOND HIGH SCHOOL	216	(10%)	103	(15%)
<b>PHYSICAL PROFILE (PULHES)</b>				
111111	1833	(78%)	435	(63%)
NOT 111111	532	(22%)	258	(37%)
<b>DEPENDENTS</b>				
NONE	1443	(61%)	337	(49%)
ONE	369	(16%)	132	(19%)
TWO OR MORE	553	(23%)	224	(32%)
<b>MEAN GT SCORE</b>	107.1		106.7	
(Standard Deviation)	(15.0)		(13.7)	
<b>MEAN AGE, YEARS</b>	23.2		25.4	
(Standard Deviation)	(4.7)		(5.5)	
<b>MEAN TIME AT POST, MONTHS</b>	19.8		17.6	
(Standard Deviation)	(19.9)		(17.1)	



#### APPENDIX A: AREAS OF FUTURE REPORTS

The following are working titles of technical reports for which data is currently being analyzed:

T1: The Health Consequences of Deployment. Part I: Data Gathering. Department of Military Psychiatry, WRAIR, WASHINGTON DC. 20012. 1982.

T2: Types and Rates of Outpatient Sickcall Visits of Active Duty and Their Family Members. Department of Military Psychiatry, WRAIR, WASHINGTON DC. 20012. 1982.

T3: Comparison of Outpatient Sickcall Visits for a Sample of Combat Arms and Support Soldiers.

T4: Additional Survey of Injuries of Combat Soldiers.

T5: Impact of Activity and Transitional States on Combat Arms Soldiers Outpatient Sickcall Rates.

T6: Variation in Outpatient Sickcall Visits Among Matched Combat Arms Battalions.

T7: Demography, Unit Personnel Turnover and Outpatient Visits.

T8: Identification of Repeated Users of Health Care Resources

T9: Characterization of Active Duty and Family Members Who Make Mental Health Visits.

**APPENDIX B: REASON FOR VISIT CODES AND MODULES INCLUDED IN  
MAJOR SUMMARY CATEGORIES.**

INJURY	J001-J999	Injuries and Adverse Effects Module
MUSCULAR/SKELETAL	S900-S999	Symptoms Referrable to the Musculoskeletal System
	D900-D949	Diseases of the Musculoskeletal System and Connective Tissue
GENERAL SYMPTOMS	S001-S099	General Symptoms
MENTAL HEALTH	S100-S199	Symptoms Referable to Psychological and Mental Disorders
	D300-D349	Mental Disorders
	T700-T799	Social Problem Counseling
NERVOUS SYSTEM	S200-S259	Symptoms Referable to Nervous System (excluding sense organs)
	D350-D399	Diseases of the Nervous System
EYE AND EAR	S300-S399	Symptoms Referable to the Eyes and Ears
	D400-D499	Disease of the Eye and Ear
HEART AND BLOOD	S260-S299	Symptoms Referable to the Cardiovascular and Lymphatic System
	D250-D299	Disease of the Blood and Blood-Forming Organs
HEART AND BLOOD (CONT)	D500-D599	Disease of the Circulatory System
RESPIRATORY	S400-S499	Symptoms Referrable to the Respiratory System
	D600-D649	Diseases of the Respiratory System

DIGESTIVE	S500-S639	Symptoms Referrable to the Digestive System
	D650-D699	Diseases of the Digestive System
	S640-S829	Symptoms Referable to the Genito-Urinary System
	D700-D799	Diseases of the Genito-Uninary System
SKIN,HAIR & NAILS	S830-S899	Symptoms Referrable to the Skin, Nails and Hair
	D800-D899	Diseases of the Skin and Subcutaneous Tissue
TEST RESULTS	R100-R700	Test Results Module
TREATMENT	T100-T699, T800-T899	Medications, Preoperative and Postoperative Care, Specific Types of Therapy, Specific Therapeutic Procedures, Medical Counseling, Progress Visit NEC
DIAGNOSTIC-SCREENING	X100-X599	Diagnostic, Screening and Preventive Module
ADMINISTRATIVE	A100-A140	Administrative Module
OTHER AND UNCODABLE	D001-D249	Infective and Parasitic Diseases, Neoplasms, and Endocrine, Nutritional and Metabolic Diseases.
	D950-D999	Congenital Anomalies, Perinatal Morbidity and Mortality Conditions
	U990-U999	Uncodable Entries Module

(M/S & I) MUSCULAR/  
SKELETAL COMPLAINTS  
AND INJURIES

J001-J999	Injuries and Adverse Effects Module
S900-S999	Symptoms Referrable to the Musculoskeletal System
D900-D949	Diseases of the Musculoskeletal System and Connective Tissue

(O D/S) OTHER  
DISEASES AND SYMPTOMS

S001-S899	Symptoms, NEC
D001-D899	Diseases, NEC

(O) OTHER

X100-X599	Diagnostic, Screening and Preventive Module
T100-T899	Treatment Module
R100-R700	Test Results Module
A100-A140	Administrative Module
U990-U999	Uncodable Entries Module

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APPENDIX C: REASON FOR VISIT CODES INCLUDED IN EACH CATEGORY OF VISIT FOR SKIN HAIR AND NAIL MODULE, TABLE 3.

<u>TYPE OF VISIT</u>	<u>REASON FOR VISIT CODES</u>
BLISTERS AND OTHER LESIONS	S865 Skin Lesion
SKIN INFECTIONS (ACNE, BOILS, ETC.)	S830 Acne
	S840 Infections Of The Skin
	D800 Boil, Abscess, Etc.
CALLUS & OTHER GROWTHS	S855 Other Growths Skin
POISON IVY, RASHES & OTHER SKIN IRRITATIONS	S860 Skin Rash
	S870 Skin Irritation
	D825 Other skin diseases
INGROWN NAIL & OTHER NAIL PROBLEMS	S885 Symptoms Of Nails

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OTHER SYMPTOMS & DISEASES OF  
SKIN, HAIR AND NAILS

D810 Seborrheic Dermatitis  
S835 Skin Discoloration  
S880 Other Symptoms Of Skin  
S890 Symptoms Of Hair, Scalp  
S895 O Skin, Nail/Hair  
S875 Swelling Skin  
D805 Impetigo  
D810 Seborrheic Dermatitis  

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D820 Psoriasis

APPENDIX D: REASON FOR VISIT CODES INCLUDED IN EACH CATEGORY OF VISITS FOR INJURY MODULE, TABLE 4.

TYPE OF VISIT	REASON FOR VISIT CODE
INSECT BITE	J755 Insect Bite
LOWER EXTREMITIES	J020-J030 Fracture Lower Limb
	J220 Cuts/lower extremity
	J115-J120 Sprn/Strn Back/Ankle
	J220 Cuts/Lower Extremity
	J315 Punct/Lower Extremity
	J420 Abra/Bru Lower Extrem
	J530-J545 Lower Limb Injury Nos
	J715 Burn Extremities
TRUNK	J015 Fracture/Trunk
	J110 Sprn/Strn Back
	J215 Cuts Trunk
	J415 Abra/Bru Lower Extrem
	J515 Back injury nos
	J520J-525 Chest/Hip Abd Injury
	J710 Burn Trunk

HEAD FACE NECK

J005 Fracture Head  
J105 Sprn/Strn Neck  
J205-J210 Cut Head/Neck/Face  
J305 Puncture Head  
J405 Abra/Bru Head  
J505-J510 Head/Eye Injury Nos  
J600 Forgn Bdy/Eye  
J705 Burn Head Neck

OTHER ACCIDENTS & INJURIES

J610-J620 Forgn Bdy/Skin  
J750 Sun/Wind Burn  
J760 Animal/Human Bite  
J800-J820 Accident/Violence  
J840 Uncons On Arrival  
J900-J925 Poison/Drug/Alcoh

UPPER EXTREMITIES

J035-J045 Frac Arm/Wrist/Hand  
J125 Sprn/Strn Wrist  
J225 Cuts Upper Extremity  
J320 Punct Upper Extremity  
J425 Abra/Bru Upper Extrem  
J550 Shoulder Inj Nos  
J560 Elbow Inj Nos  
J570 Hand Inj Nos  
J720 Burn Nos



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UNSPECIFIED OR MULTIPLE INJURY

J050 Fracture Nos

J130 Sprn/Strn Nos

J230 Cuts Nos

J325 Puncture Nos

J430 Abra/Bru Nos

J575 Inj Nos Multiple

J720 Burn Nos

SPECIFIED JUMP INJURY

J950 Jump Injury Nos

**APPENDIX E: REASON FOR VISIT CODES INCLUDED IN EACH CATEGORY  
OF VISITS FOR MENTAL HEALTH MODULE, TABLE 5.**

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<b>TYPE OF VISIT</b>	<b><u>REASON FOR VISIT CODE</u></b>
<b>MARITAL/FAMILY</b>	<b>T705 Marital Problems</b>
	<b>T710 Par/Child Problems</b>
	<b>T715 Other Fam Problems</b>
<b>OCCUPATIONAL, SOCIAL ECONOMIC OR EDUCATIONAL</b>	<b>T700 Econ Problems</b>
	<b>T725 Occupa Problems</b>
	<b>T730 Social Adj Problems</b>
	<b>T740 Other Social Problems</b>
<b>ANXIETY, DEPRESSION AND SLEEP DISORDERS</b>	<b>S100 Anx/Bad Nerv Sym</b>
	<b>S110 Depression Sym</b>
	<b>S135 Sleep Problems</b>
<b>ANGER, INDENTITY OR BEHAVIORAL PROBLEM</b>	<b>S115 Anger Symptoms</b>
	<b>S120 Identity problem</b>
	<b>S130 Behav Distur Gen</b>

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PERSONALITY DISORDERS AND  
OTHER PSYCHIATRIC DISORDERS

S160 Psychosex Problems  
S165 Other Psych Sym  
D315 Eye Infect/Inflammation  
D330 Appear Of Eyes

DRUG, ALCOHOL

S145 Alcohol Rel Problems  
S150 Abnorm Drug Use

PSYCHIATRIC EXAM

ADMINISTRATIVE

A1402 Cmd Psych Exam  
X130 Gen Psych Exam

OTHER REASONS

Codes Not Elsewhere Classif

NO COMPLAINT GIVEN

U9970 No Complaint